

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

10195

County

Dunham

Village or City

Carmichael

(No.

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

254

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hattie May Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Oct 29, 1914
(Month) (Day) (Year)

7 AGE

1 yrs. 19 mos. 19 ds. OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Child

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Dunham Co, Ind

PARENTS

10 NAME OF FATHER

William Anderson

11 BIRTHPLACE OF FATHER (State or country)

Yalbot Co Ind

12 MAIDEN NAME OF MOTHER

Mary L. Price

13 BIRTHPLACE OF MOTHER (State or country)

Dunham Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Anderson

(Address)

Carmichael Ind

15

Filed Oct 19, 1914

W. L. McConn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1914, to Oct 18, 1914.

that I last saw her alive on Oct 18, 1914.

and that death occurred on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Indigestion

Contributory Secondary

(Duration) yrs. mos. 4 ds.

(Signed)

J. M. Stack

(Duration) yrs. mos. 2 ds.

Oct 18, 1914 (Address) Wyco, W. Va.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Carmichael Ind

Oct 19, 1914

20 UNDERTAKER

ADDRESS

None

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

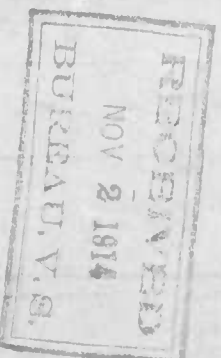
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As thesia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10196

County

Queen Anne's County

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 25-3

Village or City

Lovepoint

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Matha Elizabeth Austin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

white

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

6 DATE OF BIRTH

April 11th day, 1886

7 AGE

28 yrs. 5 mos. 28 ds.

If LESS than

1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Queen Anne's Co. Md.

10 NAME OF FATHER

Jas. B. Hess

11 BIRTHPLACE OF FATHER

(State or country)

Harford Co. Md.

12 MAIDEN NAME OF MOTHER

Annie M. Friel

13 BIRTHPLACE OF MOTHER

(State or country)

Philadelphia Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie M. Hess

(Address)

Lovepoint Md.

15

Filed

Oct 16, 1914 L. C. Thomas

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct.

9

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July

1913

to

Oct 9

1914

that I last saw him alive on

Oct 7

1914

and that death occurred on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Chas. E. Fyfe

M. D.

Oct 10, 1914 (Address) Stevensville

*State the DISEASE CAUSING DEATH, or, in deaths from violent CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Near Stevensville Md.

Oct 11, 1914

20 UNDERTAKER

ADDRESS

Frank C. Thomas Stevensville Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

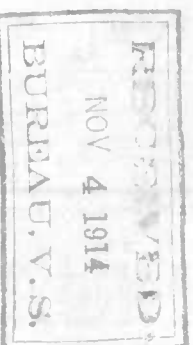
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculous of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recober wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Queen Anne's</u>		10197 <u>157</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Winchester</u>		(No., St.; Ward)		Registration Dist. No. <u>254</u>	
2 FULL NAME <u>Benjamin F. Beecher</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Oct 15, 1883</u> (Month) (Day) (Year)					
7 AGE <u>31</u> yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Sailor</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Queen Anne's Co</u>					
PARENTS	10 NAME OF FATHER <u>James Beecher</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Queen Anne's Co</u>				
	12 MAIDEN NAME OF MOTHER <u>Louisa Collier</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Queen Anne's Co</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Luther T. Beecher</u> (Address) <u>Fords Store Rd</u>					
15 Filed <u>Oct 16, 1914</u> <u>W. McEwen</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 15, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from, 191...., to, 191...., that I last saw him alive on, 191...., and that death occurred on the date stated above, at m.					
The CAUSE OF DEATH* was as follows: <u>Suicide. Committed by shooting himself in head. Voluntary and feloniously, was verdict of Coroner Jury.</u> (Duration) yrs. mos. ds.					
Contributory Secondary					
(Duration) yrs. mos. ds.					
(Signed) <u>John F. Quail, acting coroner</u> , M.D. <u>Oct 16, 1914</u> (Address) <u>Fords Store Rd</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?					
Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Fords Store Rd</u>					DATE OF BURIAL <u>Oct 16, 1914</u>
20 UNDERTAKER <u>W. McEwen</u>					ADDRESS <u>Queen Anne's Co</u>

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

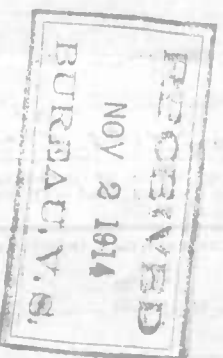
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH 10198
County Queen Anne

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 252

Village or City Currisville (No. 170) St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Clarence Washington Burke

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colord 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Augt. 24, 1892
(Month) (Day) (Year)

7 AGE 22 yrs. 1 mos. 22 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Queen Anne Co.

10 NAME OF FATHER Albert Burke

11 BIRTHPLACE OF FATHER (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Indiana Wilson

13 BIRTHPLACE OF MOTHER (State or country) Queen Anne Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Burke (Father)

(Address) Centreville Md

15 Filed Oct 17, 1914 Post. W. Robbins
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 16, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Gunsbat Wound
Accident

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. E. Thompson M. D.
10-18-, 1914 (Address) Centreville Md

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18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Currisville Md DATE OF BURIAL Oct 18, 1914

20 UNDERTAKER J. H. Dawson ADDRESS Centreville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

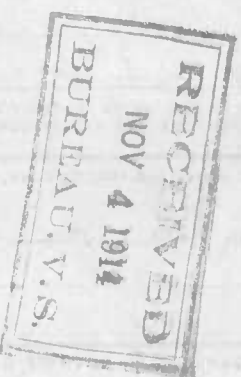
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oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

10199

County

Village or City

(No.)

St.; Ward)

2 FULL NAME

Registration Dist. No. 242

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Sept. 9

1894

(Month)

(Day)

(Year)

7 AGE

17

yrs.

mos.

29

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Ind

PARENTS

10 NAME OF FATHER

Stephen Dyer

11 BIRTHPLACE OF FATHER

(State or country)

Ind.

12 MAIDEN NAME OF MOTHER

Alberta Richardson

13 BIRTHPLACE OF MOTHER

(State or country)

Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Stephen Dyer

(Address)

Anthrville Ind

15

Filed

10-26-1914

Post. Waddins

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 25

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Oct. 17

1914, to

Oct. 25

1914

that I last saw him alive on

Oct. 25

1914

and that death occurred on the date stated above, at

20

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(Duration) yrs. mos. 21 ds.

Contributory

Secondary

(Signed)

H. F. M. Johnson

M. D.

10/26

1914 (Address)

Anthrville Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted, if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hillsboro Md

27

1914

20 UNDERTAKER

ADDRESS

Jos. G. Dawson Centerville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

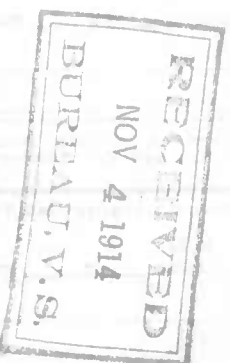
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH

10200

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Anne Arundel

(79)

Registration Dist. No.

230

Village or City

New River

(No.)

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME

Eben Glandine

PERSONAL AND STATISTICAL PARTICULARS

SEX

Male

COLOR OR RACE

White

SINGLE, MARRIED, WIDOWED, OR DIVORCED

(Write the word)

Single

DATE OF BIRTH

About 71 yrs. mos. ds. (Month) (Day) (Year)

AGE

About 71 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (State or country)

Md.

PARENTS

NAME OF FATHER

Eben Glandine

BIRTHPLACE OF FATHER (State or country)

Md.

MAIDEN NAME OF MOTHER

Martha Ford

BIRTHPLACE OF MOTHER (State or country)

Md.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Glandine

(Address)

Marydel Md.

Filed

Oct 28, 1914 R.H. Phillips

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH

10 28, 1914 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

10-20-1914, to 10-28-1914

that I last saw him alive on 10-28-1914

and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows

Valvular Heart disease

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed)

J.R. Phillips, M.D.

10-28, 1914 (Address) Simplicity

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Blessed Church

Oct 30, 1914

UNDERTAKER

ADDRESS

J.L. Phipps

Marydel Md.

If more blanks are needed, address State Registrar, 6 M. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

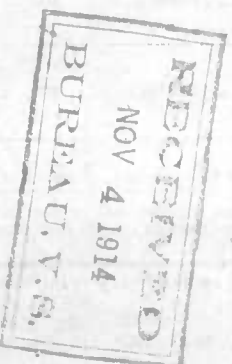
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH **10201**
 County Queen Anne's
 Village or City Marydel P. D. (No. 120) St.; Ward)
 2 FULL NAME: Emock Hay

STATE OF MARYLAND CERTIFICATE OF DEATH

 Registration Dist. No. 250

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male
 4 COLOR OR RACE white
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
 (Write the word)
 6 DATE OF BIRTH July 12 1849
 (Month) (Day) (Year)
 7 AGE 65 yrs. 2 mos. 20 ds. If LESS than 1 day, hrs. OR min. ?
 8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Delaware
 10 NAME OF FATHER John Hay
 11 BIRTHPLACE OF FATHER (State or country) No history
 12 MAIDEN NAME OF MOTHER Ruth Clough
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

 (Informant) George Hay
 (Address) Marydel - P. D.

 15 Filed Oct 5 1914 R. H. Phillips
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

 16 DATE OF DEATH Oct 2, 1914
 (Month) (Day) (Year)

 17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1914, to Oct 1, 1914,

 that I last saw him alive on July 20, 1914,

 and that death occurred on the date stated above, at 5/40 a. m.

The CAUSE OF DEATH* was as follows:

Bright's Disease and
Chronic Catarrh of Stomach
 (Duration) 1 yrs. 4 mos. ds.

Contributory (Secondary)

 (Signed) H. H. Dodson M. D.
Oct 2, 1914 (Address) Hortly - Del

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

 19 PLACE OF BURIAL OR REMOVAL Fennelville DATE OF BURIAL Oct 4, 1914

 20 UNDERTAKER Gas Y. Phillips ADDRESS Marydel
md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

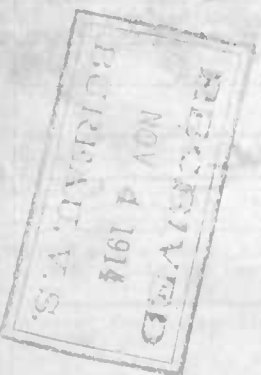
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

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1 PLACE OF DEATH

10202

County

Anne Arundel

Village or City

Centreville

(No.)

St.; Ward)

Registration Dist. No.

212

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Garrison Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

Married

6 DATE OF BIRTH

Don't Know

(Month)

(Day)

(Year)

7 AGE

about 47 years

If LESS than

1 day.....hrs.

OR.....min. ?

yrs. mos. ds.

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF FATHER

Frisby Jones

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Rebecca Jones

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Wm. Wilmer

(Address)

Centreville Md

15

Filed

Oct. 9, 1914

Robt. W. Edlin

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct.

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 20

1914

to

Oct. 8

1914

that I last saw him alive on

Oct. 5

1914

and that death occurred on the date stated above, at

50 m.

The CAUSE OF DEATH* was as follows:

Chronic Inflammation

Tubercle

(Duration)

yrs.

mos.

ds.

Contributor

Secondary

(Signed)

H. F. W. Johnson M. D.

10/9

1914

(Address)

Centreville Md.

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Centreville

Oct. 9

1914

20 UNDERTAKER

ADDRESS

Robt. W. Edlin

Centreville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

10203

County

Village or City

(No.)

St.; Ward)

Registration Dist. No. 28-3

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Aug 18, 1891

7 AGE

23

yrs.

2

mos.

1

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

systemman

9 BIRTHPLACE (State or country)

Maryland

10 NAME OF FATHER

Stephen Lane

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Amanda Wilson

13 BIRTHPLACE OF MOTHER (State or country)

R. A. Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Alexander Johnson

(Address)

Stevensville, Md

15

Filed

Oct 18, 1914 F. C. Thomas

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 18, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

1914, to 1914,

that I last saw h. alive on 1914,

and that death occurred on the date stated above, at 4.9, m.

The CAUSE OF DEATH* was as follows:

Acute alcoholism

(Duration) yrs. mos. ds.

Contributory Secondary

Exposure

(Duration) yrs. mos. ds.

(Signed)

Chas E. Byrde

M. D.

Oct 18, 1914 (Address) Stevensville, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Stevensville Md Oct 19, 1914

20 UNDERTAKER

ADDRESS

F. C. Thomas Jr Stevensville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

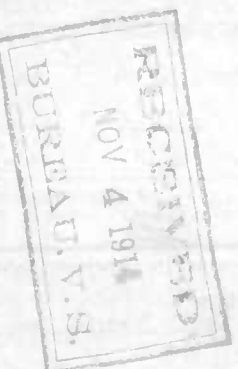
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated, under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

10204

County

Queen Anne's

Village or City

Curtisville

(No.)

St.

Ward)

2 FULL NAME

Elizabeth Frances Keating

Registration Dist. No.

252

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widowed

6 DATE OF BIRTH

Oct 11

1842

(Month)

(Day)

(Year)

7 AGE

71 yrs 10 mos 21 ds.

If LESS than 1 day,.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Ladys

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Curtisville, Md.

PARENTS

10 NAME OF FATHER

Augustus McCable

11 BIRTHPLACE OF FATHER

(State or country)

Curtisville, Md.

12 MAIDEN NAME OF MOTHER

Margaret Rawlings

13 BIRTHPLACE OF MOTHER

(State or country)

Annapolis, Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mrs. Julia Haddon

(Address)

Curtisville, Md.

15

Filed

10-7-1914

John W. Addins

Regt.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 6

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 27, 1914, to Oct 6, 1914,

that I last saw him alive on Oct 6, 1914

and that death occurred on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration)

yrs.

mos.

9 ds.

Contributory
Secondary

La Grippe

(Duration)

yrs.

mos.

14 ds.

(Signed)

Oct 6, 1914 (Address) Curtisville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Curtisville Md

10-8-1914

20 UNDERTAKER

ADDRESS

John W. Addins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

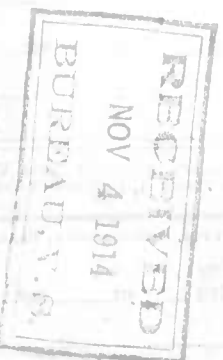
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc., State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Repeater wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

10205

County Queen AnneSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 250Village or City Millington

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John Killip

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH March, 23, 1826
(Month) (Day) (Year)

7 AGE 88 yrs. 6 mos. 11 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Germany

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (State or country) Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas L. Killip(Address) Millington, Md.

15 Filed Per 6-66, 1914 R. A. Phillips
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 4th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 10, 1914, to October 4, 1914.

that I last saw him alive on Oct 3, 1914

and that death occurred on the date stated above, at 12:50 a. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

Contributory (Secondary) edema of lungs

(Duration) yrs. mos. ds.

(Signed) Herbert Bates, M. D.

10/4, 1914 (Address) Millington, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Millington, Md. Sept 7, 1914

20 UNDERTAKER ADDRESS

John L. Smith Millington, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

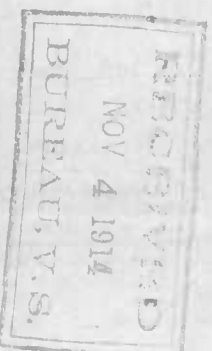
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Queen Anne 10206Village or City Winchester (No. 28) St.; WardSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 28
25-4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME

Margaret D. Lynch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

5 DATE OF BIRTH October 31, 1898
(Month) (Day) (Year)

7 AGE 15 yrs. 11 mos. 28 ds. If LESS than 1 day.....hrs. OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) attending school

9 BIRTHPLACE

(State or country) Winchester, Md.

PARENTS

10 NAME OF FATHER Thos. W. Lynch

11 BIRTHPLACE OF FATHER (State or country) Chertown, Md.

12 MAIDEN NAME OF MOTHER Mary J. Honey

13 BIRTHPLACE OF MOTHER (State or country) Queen Anne Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos W Lynch
(Address) Jonas Stone Md

15 Filed Oct 30, 1914 W. C. McCombs

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1914, to 10-29, 1914.

that I last saw h. her alive on 10-29, 1914

and that death occurred on the date stated above, at 11:58 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. 6 mos. ds.

Contributory

Cardiac failure
(Duration) yrs. 3 mos. ds.

(Signed) J. H. Ford, M. D.
10-26, 1914 (Address) Winchester, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Jonas Stone Md DATE OF BURIAL Nov 1, 1914

20 UNDERTAKER McCombs ADDRESS Winchester

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

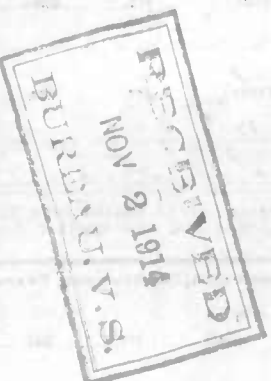
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningis, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confeital"), "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Queen Anne's</u>		10207 (43)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>New Brunswick</u>		No. <u>2</u>		Registration Dist. No. <u>255</u> St. <u>7</u> ^{dist} Ward)	
2 FULL NAME <u>Julia J. Malloy</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>Sept 27, 1857</u> (Month) (Day) (Year)					
7 AGE <u>57</u> yrs. <u>1</u> mos. <u>1</u> ds. OR <u>1</u> LESS than 1 day, hrs. min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House-keeper</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Living with son</u>					
9 BIRTHPLACE (State or country) <u>Ireland</u>					
PARENTS	10 NAME OF FATHER <u>Thos Murny</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Ireland</u>				
	12 MAIDEN NAME OF MOTHER <u>Julia Mullin</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Ireland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John J. Malloy</u> (Address) <u>Millington R 7 D</u>					
15 Filed <u>Oct 29, 1914</u> <u>L. A. Brown</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 28, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 1, 1914</u> to <u>Oct 25, 1914</u> , that I last saw her alive on <u>Oct 25, 1914</u> and that death occurred on the date stated above, at <u>about 10</u> m.					
The CAUSE OF DEATH* was as follows: <u>Cancerous Breast</u> (Duration) <u>2</u> yrs., <u>0</u> mos., <u>0</u> ds. Contributory <u>Pneumonia</u> Secondary (Signed) <u>D. I. Deady</u> , M. D. (Address) <u>Church Hill</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs., <u>0</u> mos., <u>0</u> ds. In the State <u>0</u> yrs., <u>0</u> mos., <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Catholic Cemetery Church Hill</u> DATE OF BURIAL <u>Oct 30, 1914</u>					
20 UNDERTAKER <u>J. K. Brown</u> ADDRESS <u>Church Hill</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

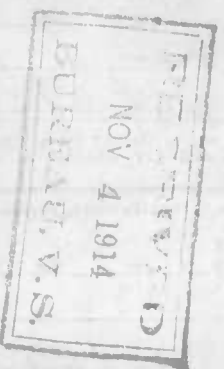
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10208
County Queen Anne's
Village or City Bainbridge (No. 103)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 28-4

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Nelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH 1836
(Month) (Day) (Year)

7 AGE 78 yrs. 0 mos. 0 ds. OR 0 min. ?
If LESS than 1 day, hrs.

8 OCCUPATION
(a) Trade, profession, or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (State or country) Don't know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Benny Baker(Address) Bainbridge Md

15 Filed Oct 6, 1914 Wm C McConner
284 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 5, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from viewed the body of deceased, 1914

that I last saw him alive on Don't know, 1914
and that death occurred on the date stated above, at Don't know m.

The CAUSE OF DEATH* was as follows:

Don't know
Apparently acute indigestion
(Duration) Don't know yrs. 0 mos. 0 ds.

Contributory Heart failure
Secondary (Duration) Don't know yrs. 0 mos. 0 ds.

(Signed) J. H. Ford M. D.
10-6, 1914 (Address) Greenstown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Catholic on the way DATE OF BURIAL Oct 7, 1914

20 UNDERTAKER Wm C McConner ADDRESS Queenstown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

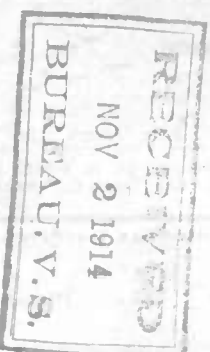
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a), *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Tuaition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Queen Anne

10269

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

255

Village or City

Pondtown

(No.)

St.:

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Pinkney Susan

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Oct 18, 1914
(Month) (Day) (Year)

7 AGE

If LESS than
1 day, hrs.

yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Pondtown Md.

PARENTS

10 NAME OF
FATHER

Joseph Pinkney

11 BIRTHPLACE
OF FATHER
(State or country)

Md.

12 MAIDEN NAME
OF MOTHER

Emma Bratcher

13 BIRTHPLACE
OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Joseph Pinkney

(Address)

Pondtown

15

Filed Oct 18, 1914

L. Allen O'Connell

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 18, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914, to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Arthur E. Lander

M. D.

Oct 18, 1914 (Address) Cunningham

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pondtown Md.

Oct 19, 1914

20 UNDERTAKER

ADDRESS

Joseph Pinkney

Millington, R.D. #1

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

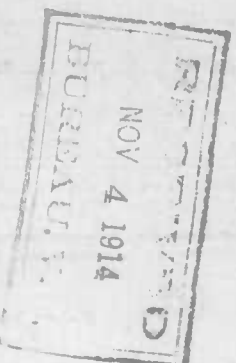
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

10210

County Innes AnneSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 254Village or City Innsmouth (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Mildred Price

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE African 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH June 12, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 4 mos. 4 ds. OR 1 day, 4 hrs. 4 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER John Price
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Martha Green
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Price
(Address) Carmichael Ave

15 Filed Oct 31, 1914 W. C. McCombs
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 30, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 27, 1914 to Oct 30, 1914
that I last saw her alive on Oct 30, 1914

and that death occurred on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Sho colitisContributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) Samuel J. Price, M. D.
Oct 30, 1914 (Address) Innsmouth

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Carmichael Ave DATE OF BURIAL Oct 31, 1914

20 UNDERTAKER None ADDRESS _____

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

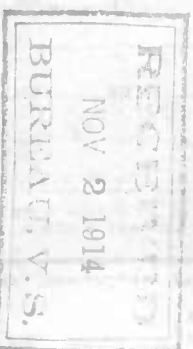
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH

10211

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Queen Anne

Registration Dist. No.

252

Village or City

Puthobury

(No.)

2d. Co Home

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Richard A. Richardson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Caucas

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

 (Month) (Day) (Year)
 10/30/1914

7 AGE

 53 yrs. — mos. — ds. OR 1 day, — hrs. — min. ?
 LESS than 1 day, — hrs. — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

"

9 BIRTHPLACE

(State or country)

Queen Anne Co.

PARENTS

10 NAME OF FATHER

Emmanuel Richardson

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Nancy

13 BIRTHPLACE OF MOTHER

(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Richardson

(Address)

Centerville Md.

15

Filed

10-30-1914 Robt. W. Eddies

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

15 DATE OF DEATH

Oct.

30

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 1

1914

to

Oct 30

1914

that I last saw him alive on

Oct 29

1914

and that death occurred on the date stated above, at 4.9. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration)

yrs.

mos.

ds.

Contributory
Secondary

Atherosclerosis

(Duration)

2

yrs.

mos.

ds.

(Signed)

J. Morgan

M. D.

Oct 30

1914

(Address)

Centerville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

Burrisville Md

DATE OF BURIAL

Nov 10

1914

20 UNDERTAKER

Robt. W. Eddies

ADDRESS

Centerville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

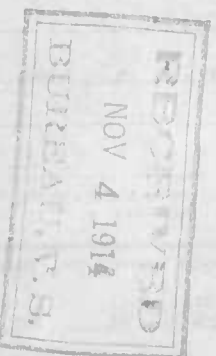
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10212
County Dunn Where

Village or City Centerville (No. _____, St.; _____ Ward)

2 FULL NAME John Rojick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)
6 DATE OF BIRTH July 25, 1912
(Month) (Day) (Year)
7 AGE 2 yrs. 7 mos. 7 ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Ind

PARENTS
10 NAME OF FATHER Jacob Rojick
11 BIRTHPLACE OF FATHER (State or country) Austria
12 MAIDEN NAME OF MOTHER Katie Lantowski
13 BIRTHPLACE OF MOTHER (State or country) Austria

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Rojick
(Address) Centerville, Ind.

15 Filed 10-3-, 1914 Robt. W. Keddies
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 252

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 7, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 16, 1914, to Oct. 4, 1914.

that I last saw him alive on Sept. 26, 1914.

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Ind. - Colic
Secondary

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Dr. F. M. Pherson M. D.
1073, 1914 (Address) Centerville Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Greenstown DATE OF BURIAL Oct. 3rd, 1914

20 UNDERTAKER Jos. G. Dawson ADDRESS Centerville Ind.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

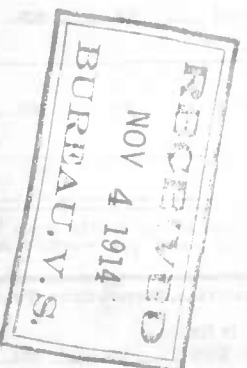
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, *septicæmia*," "PUERPERAL peritonitis," etc., State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **19213**
 County Queen Anne
 Village or City Templeville (No. RD) St. _____ Ward) 151
 2 FULL NAME Thomas Sewerd
 Registration Dist. No. 250
 [It death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS			MEDICAL CERTIFICATE OF DEATH	
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Infant</u>	16 DATE OF DEATH <u>Oct 27</u> , 191 <u>4</u> (Month) (Day) (Year)	
6 DATE OF BIRTH <u>Oct 27</u> , 191 <u>4</u> (Month) (Day) (Year)			17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 27</u> , 191 <u>4</u> , to <u>Death</u> , 191 <u>4</u> , that I last saw him alive on <u>Oct 27</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>5 P</u> m. The CAUSE OF DEATH* was as follows: <u>Premature Birth</u>	
7 AGE <u>Five Hours</u> yrs. _____ mos. _____ ds. _____ It LESS than 1 day, _____ hrs. _____ min. ?			(Duration) _____ yrs. _____ mos. _____ ds.	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) _____			Contributory _____ Secondary _____	
9 BIRTHPLACE (State or country) <u>Maryland</u>			(Duration) _____ yrs. _____ mos. _____ ds.	
PARENTS	10 NAME OF FATHER <u>James Sewerd</u>		(Signed) <u>H. H. Hodd</u> , M. D.	
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		_____, 191____ (Address) <u>Hortly - Del</u>	
	12 MAIDEN NAME OF MOTHER <u>Katie Miller</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? _____ Former or usual residence _____	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>James Sewerd</u> (Address) <u>Kenton - Del</u>				
15 Filed <u>Oct-29-14</u> , 191 <u>4</u> <u>R. H. Phillips</u> <u>Local</u> REGISTRAR				
19 PLACE OF BURIAL OR REMOVAL <u>Bursick</u>			DATE OF BURIAL <u>Oct-30-14</u> , 191 <u>4</u>	
20 UNDERTAKER <u>James Sewerd</u>			ADDRESS <u>Kenton - Del</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

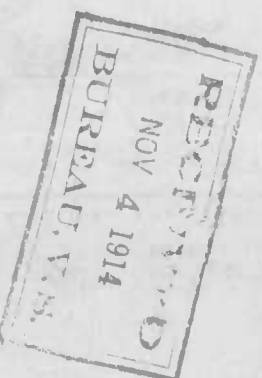
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH County <u>Queen Anne's</u>		10214		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Price Mt.</u> (No. <u>5</u>)		St. <u> </u> Ward <u> </u>		Registration Dist. No. <u>257</u>	
2 FULL NAME <u>Infant Sweeney</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>10 - 2 - 1914</u> (Month) (Day) (Year)		7 AGE <u> </u> yrs. <u> </u> mos. <u> </u> ds. OR <u> </u> min. ? It LESS than 1 day, <u> </u> hrs.			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Infant</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u>					
9 BIRTHPLACE (State or country) <u>Ind.</u>					
PARENTS	10 NAME OF FATHER <u>Robert Sweeney</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Ind.</u>				
	12 MAIDEN NAME OF MOTHER <u>Susie Powell</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Robert Sweeney</u> (Address) <u>Price Mt.</u>					
15 Filed <u>Nov 3 1914</u> <u>C. E. Smith</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>10 - 2 - 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u> </u> , 191 <u> </u> , to <u> </u> , 191 <u> </u> , that I last saw h. <u> </u> alive on <u> </u> , 191 <u> </u> , and that death occurred on the date stated above, at <u> </u> m. The CAUSE OF DEATH* was as follows: <u>Still Birth</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. Contributory <u> </u> Secondary <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. (Signed) <u>Wm W Brown</u> , M. D. <u>10 - 3 - 1914</u> (Address) <u>Ingleside Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u>					
19 PLACE OF BURIAL OR REMOVAL <u>at home</u>				DATE OF BURIAL <u> </u> , 191 <u> </u>	
20 UNDERTAKER				ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

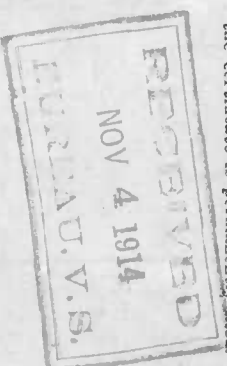
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Lucas Anne's</u>		19215		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Price</u> (No. <u>104</u>)		St.; Ward		Registration Dist. No. <u>257</u>	
2 FULL NAME <u>Leona Wright</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Col</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>4-28-</u> , 191 <u>4</u> (Month) (Day) (Year)					
7 AGE <u>3</u> yrs. <u>8</u> mos. <u>8</u> ds. It LESS than 1 day.....hrs. OR.....min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Infant -</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Ind</u>					
PARENTS					
10 NAME OF FATHER <u>John H. Wright</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Ind</u>					
12 MAIDEN NAME OF MOTHER <u>Mary Wilkerson</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Ind</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John H. Wright</u> (Address) <u>Price Ind.</u>					
15 Filed <u>Oct 6</u> , 191 <u>4</u> <u>L. E. Smith</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>10-6-</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>9-25-</u> , 191 <u>4</u> , to <u>10-6-</u> , 191 <u>4</u> , that I last saw <u>her</u> alive on <u>10-5-</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>10 A.</u> m. The CAUSE OF DEATH* was as follows: <u>Cholera Infantum</u> (Duration) <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. Contributory <u>Imperfect feeding</u> (Duration) <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. (Signed) <u>W. H. Brown</u> , M. D. <u>10-6-</u> , 191 <u>4</u> (Address) <u>Ind</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. In the State <u>2</u> yrs. <u>2</u> mos. <u>2</u> ds. Where was disease contracted, It not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Roseville Maryland</u> DATE OF BURIAL <u>Oct 7</u> , 191 <u>4</u>					
20 UNDERTAKER <u>Brown</u> ADDRESS <u>Church Hill</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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